STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northland Rehabilitation & Health Care Center	4301 NE Parvin Road Kansas City, MO 64117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and facility policy review, the facility failed to report an allegation of verbal abuse to the State Survey Agency (SSA) for one out of four residents (Resident (R) 37) reviewed for abuse out of 25 sample residents. This failure had the potential to affect resident safety at the facility. Findings include: Review of the facility's policy titled ABUSE, PREVENTION AND PROHIBITION POLICY, revised 01/24, revealed The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility Administrator or his/her designated representative in the Administrators absence. An employee or agent or any Covered individual will make or cause a report to be made to law enforcement and the facility. The Administrator, or his/her designated representative if Administrator is not present, will notify the Regional Corporate Nurse (if unavailable, the Director of Clinical Operations will be contacted). The facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. Such reports may also be made to the local law enforcement agency in the same manner. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the Administrator. The person made aware of allegations of abuse or neglect OR the Administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than 2 hours, or per state regulations, after the allegation is made. Review of R37's Admission Record located in the Profile tab of the electronic medical record (EMR), revealed admission to the facility on [DATE] with diagnoses including depression and anxiety. Review of R37's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 06/25/24 11:31 AM, R37 stated she was abused by a staff member in the past. She stated that she had a procedure on her head to relieve swelling and that has affected her memory. But she stated the staff was Certified Nursing Assistant (CNA) 7 and after the incident occurred she wrote a four-page report about what happened on a yellow note pad and gave it to the former Assistant Director of Nursing (FADON) who then gave it to the former Administrator. She stated she asked that CNA7 was allowed to remain in her hall but was not allowed to come into her room to provide care for her or the roommate. She stated CNA7 used foul language towards her specifically the f-bomb, and she remembered it was physical, but she was unable to remember the specifics due to effects of stroke. R37 stated she still saw CNA7 all the time in passing and it did bother her sometimes because seeing her brought back unpleasant memories. She stated all she heard was how wonderful CNA7 was but then why did she have to be abusive towards her. During an interview on 06/27/24 at 10:39 AM, FADON stated she was the former ADON until April of 2024. She stated that R37 gave her a post it notes that CNA7 was rude to her and R37 did not want her to be her CNA anymore. FADON stated she thought it was around Summertime 2023. She stated she reported it to the Administrator at the time, but she did not think it was reported to the state. She stated she spoke with R37, but she could not remember what she meant by the staff was rude but there was nothing documented. She stated there was no documentation to show that the allegations were investigated. During an interview on 06/27/24 at 12:18 PM, CNA7 stated she had provided care to R37 in the past, but it had been a long time. She stated she was asked by a charge nurse not to provide care to R37, but she was unable to remember which charge nurse it was. She stated that she was told by other residents that R37 made allegations that she called the resident a bitch and that she reported that to a charge nurse, but she was not sure who. She stated she was never interviewed about any of the allegations or asked to write a statement. She stated there was never any follow-up after she was removed from providing care to R37, but she was still allowed to work in the hall where R37's room was located. During an interview on 06/28/24 at 2:54 PM, the Director of Nursing (DON) stated the allegations should have been reported to ensure the safety for all the residents. She stated after any allegation of abuse involving staff, that staff should be immediately removed from the care area and suspended pending the outcome of the investigation. She stated the charge nurse would be responsible for reporting the allegations of verbal abuse to management.

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40902

Based on record review, interview, and facility policy review, the facility failed to thoroughly investigate an allegation of verbal abuse for one of four residents (Resident (R) 37) reviewed for abuse out of 25 sample residents. This had the potential to affect resident safety in the facility.

Findings include:

Review of the facility's policy titled, ABUSE, PREVENTION AND PROHIBITION POLICY, revised 01/24, revealed Resident abuse must be reported immediately to the Administrator', The facility Administrator will ensure a thorough investigation of alleged violations of resident rights and document appropriate action While a facility investigation is under way steps will be taken to prevent further abuse. If a person is identified in the allegation of abuse, that person will not be allowed to have access to the facility while the investigation is in Progress' except to meet with the administrator, as part of the investigation process. The person identified in the allegation of abuse will have no contact with residents or employees during the investigation process.

Review of R37's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including depression and anxiety.

Review of R37's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition.

During an interview on 06/25/24 11:31 AM, R37 stated she was abused by a staff member in the past. She stated that she had a procedure on her head to relieve swelling and that has affected her memory. But she stated the staff was Certified Nursing Assistant (CNA) 7 and after the incident occurred she wrote a four-page report about what happened on a yellow note pad and gave it to the former Assistant Director of Nursing (FADON) who then gave it to the former Administrator. She stated she asked that CNA7 was allowed to remain on her hall but was not allowed to come into her room to provide care for her or her roommate. She stated CNA7 used foul language towards her specifically the f-bomb, and she remembered it was physical, but she was unable to remember the specifics due to effects of stroke. She stated she still saw CNA7 all the time in passing and it did bother her sometimes because seeing her brought back unpleasant memories. She stated all she heard was how wonderful CNA7 was but then why did she have to be abusive towards her.

During an interview on 06/27/24 at 10:39 AM, FADON stated she was the former ADON until April of 2024. She stated that R37 gave her a post it notes that CNA7 was rude to her and R37 did not want her to be her CNA anymore. FADON stated she thought it was around Summertime 2023. She stated she reported it to the Administrator. She stated she spoke with R37, but she could not remember what she meant by the staff was rude but there was nothing documented. She stated there was no documentation to show that the allegations were investigated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 06/27/24 at 12:18 PM, CNA7 stated she provided care to R37 in the past, but it had been a long time. She stated she was asked by a charge nurse not to provide care to R37, but she was unable to remember which charge nurse it was. She stated that she was told by other residents that R37 made allegations that she called the resident a bitch and that she reported that to a charge nurse, but she was not sure who. She stated she was never interviewed about any of the allegations or asked to write a statement. She stated there was never any follow-up after she was removed from providing care to R37, but she was still allowed to work in the hall where R37's room was located. During an interview on 06/28/24 at 2:54 PM, the Director of Nursing (DON) stated the allegations should have been investigated to ensure safety for all the residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on record review and interview, the facility failed to ensure the care plan was revised for two of three residents (Resident (R) 345 and R3) reviewed for care plan accuracy of 25 sample residents. Specifically, the facility failed to identify the inaccurate medical diagnosis for R345 and did not revise the care plan to address hospice services for R3. Failure to update the care plan could result in the residents not receiving care to meet their specific needs. Findings include: 1. Review of R345's Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed a diagnosis of dehydration. Review of R345's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/16/24 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Review of R345's Care Plan under the Care Plan tab of the EMR, revealed [R345] has dehydration or potential fluid deficit as a focus area with an initiation date and revision date of 06/10/24. R345's Care Plan revealed Monitor and document intake and output as per facility policy, and Lab work: blood urea nitrogen (BUN), (test that measures the amount of urea nitrogen that's in blood), and creatinine, (waste product that comes from the digestion of protein in food and the normal breakdown of muscle tissue), as ordered, as interventions related to the focus area. Review of R345's EMR revealed there was no order for monitoring or documentation of fluid intake and urine output. Review of R345's EMR revealed there was no BUN and creatinine lab work ordered or having been completed and documented. During an interview on 06/27/24 at 1:54 PM, the Director of Nursing (DON) stated, His care plan could just be stating what we would do if there were no orders, to monitor labs and Input and Output (I/O's) and labs. He may have diagnosis for it, but it could be an old diagnosis. We will monitor it and see if it is an actual diagnosis, but like I said, it could be an old one. During an interview on 06/27/24 at 2:35 PM, the DON stated, He was here before. The previous care plan triggered dehydration. He had it as a diagnosis during his last stay and on his care plan then. We just haven't updated his care plan, yet which would not include the diagnosis of dehydration. Like I said, things have changed so much in the last two weeks. I don't know how things were run before, but we did things differently where I worked before. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/28/24 at 12:20 PM, Licensed Practical Nurse (LPN) 3 stated, Assistant Director of Nursing (ADON) 1, MDS Coordinator LPN (MDSCL), and MDS Coordinator RN (MDSCR) . enter the meds, treatments, MDS, and care plan on new admissions. If it's a previous resident, we have to do the same process as they're a new resident . If I see a diagnosis that is inaccurate (such as dehydration), I call the Dr. During an interview on 06/28/24 at 12:36 PM, the ADON1 stated, MDS does the initial care plans and baseline care plans if they have been a previous patient. The nurses implement the interventions and make any changes that day . MDS checks the accuracy. During an interview on 06/28/24 at 12:47 PM, the Assistant Director of Nursing (ADON) 2 stated, MDS is responsible for entering the diagnosis. They enter it in the EMR when they get the referral information. Then after they're admitted , it uploads as a new admission into the EMR. The care plan populates right away . The clinical team, (DON, ADONs, and MDS) verify the changes during the daily clinical meeting along with social services and therapy. Readmissions are treated the same way as a new admission MDS should check to be sure they're accurate. During an interview on 06/28/24 at 1:05 PM, MDSCL stated, MDSCR and I enter the diagnosis and baseline care plan . If they are a prior resident, we restart the old care plan . We still have within the five days to update the old care plans when they are readmitted . We should have gone through the old care plan and double checked it for accuracy, but it got missed. During an interview on 06/28/24 at 2:19 PM, the DON stated, The immediate care plans are done upon admission and automatically populate . Until [R345] was brought up, I didn't know MDS repopulated the old care plans and used them. They have five days to review them and correct them after admission. 26006 2. Review of R3's Admission Record, located in the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease/dementia with agitation. Review of R3's significant change MDS assessment, with an ARD of 05/21/24 and located in the MDS tab of the EMR, revealed she was rarely/never able to understand others or make herself understood and had severely impaired cognition. She received hospice services. Review of R3's June 2024 Administration Record under the Orders tab of the EMR revealed a physician's order, dated 05/08/24, to admit R3 to hospice services for a diagnosis of dementia. Review of R3's Care Plan, dated 06/05/24 and located in the Care Plan tab of the EMR, revealed, [R3] has a terminal prognosis r/t [related to] Alzheimer's Disease. However, there were no goals or interventions documented to address the terminal prognosis. The Care Plan also documented, Advanced Directive/End of Life Care Plan. [R3] is approaching the end of life at this time. However, the approaches only addressed her code status of Do Not Resuscitate and did not include the provision of hospice services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Collaborative Care Plan, dated 05/07/24 and located in R3's hospice binder at the Nurses' Station, revealed the plan was to provide nurse visits once per week, aide visits twice per week, and social work and chaplain visits once per month. Under Other treatment plans documented, Foley Cath [catheter] change, diet/feedings, lab tests/diagnostic tests (with hospice approval), medication - see medication list. The section to list the party responsible for providing the necessary treatment plan (whether hospice staff or facility staff) was left incomplete. During an interview on 06/28/24 at 8:23 AM, the Administrator stated the facility did not have a policy addressing coordination of care between the facility staff and the hospice provider. During an interview on 06/28/24 at 9:02 AM, Certified Nurse Aide (CNA) 4 stated she provided the care R3 needed on a daily basis and hospice provided extra care beyond the standard care the facility provided. She stated the hospice staff used a communication binder and communicated during each visit regarding the care provided. She stated the Care Plan would populate R3's Kardex to indicate what care needed to be provided. During an interview on 06/28/24 at 1:19 PM, the MDSCL stated the nursing staff communicated to her when a resident went on hospice, and the Care Plan should have been updated right away to address coordination of care with hospice. The MDSCL stated she noticed last night that R3's Care Plan did not include hospice services, so she had added that R3 was on hospice. She stated, however, that she had not yet seen the hospice documents and so had not included any information yet regarding coordination of care with hospice. During an interview on 06/28/24 at 1:58 PM, the DON stated coordination of care with hospice providers should have been included in the Care Plan, which would then populate the Kardex to communicate to the direct care staff. The DON stated the MDSC was responsible for inputting the hospice Care Plan as soon as hospice services were implemented, and the Care Plan should have reflected the services hospice was providing for R3.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure pressure ulcer treatment orders and pressure ulcer prevention measures were implemented for one of two residents (Resident (R) 3) reviewed for pressure ulcers of 25 sample residents. These failures had the potential to lead to wound deterioration or the development of avoidable pressure ulcers. Findings include: Review of the facility's policy titled, Pressure Ulcer/Pressure Injury Prevention (PUP/PIP) dated March 2022 and provided by the facility, revealed, A pressure ulcer/ injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue. A facility must . implement, monitor, and modify interventions to attempt to stabilize, reduce, or remove underlying risk factors; and if a PU/PI is present, provide treatment to heal it and prevent the development of additional PU/PI's [sic]. Review of R3's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including dementia, venous insufficiency, muscle weakness, and peripheral vascular disease. Review of R3's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/24 and located in the MDS tab of the EMR, revealed she was rarely/never able to understand others or make herself understood and staff assessed her with severely impaired cognition. She was at risk for the development of pressure ulcers but had no current pressure ulcer. She received a pressure-reducing device for her chair and bed. R3 required substantial to maximal assistance with bed mobility and moving from lying to sitting or sitting to lying. Review of R3's Care Plan, dated 06/05/24, revealed, [R3] has actual impairment to skin integrity r/t [related to] diagnosis of PVD [peripheral vascular disease], fragile skin to BLE [bilateral lower extremities], lymphedema. The approaches included, Float heels while in bed as tolerated .Follow orders for treatment of injuries .Administer treatments as ordered and monitor for effectiveness .[and] Monitor pressure areas for changes in color, sensation, temperature and report any change to nurse. 1. Review of R3's Skin Check Weekly & [and] PRN [as needed] assessments, located in the Assessments tab of the EMR, revealed: -On 05/17/24, there were no skin issues. -On 05/24/24, Open area noted to outer left foot measures 1.5 [centimeters (cm)] x [by] 1 [cm] x US [unstageable] with slough to center and peri wound intact. Treatment order obtained, care plan reviewed and update not needed. -On 05/31/24, there were no skin issues. -On 06/07/24, there were no skin issues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's Health Status Note, written by Licensed Practical Nurse (LPN) 2, dated 05/24/24 and located in the Progress Notes tab of the EMR, revealed [R3] noted to have open area to outer left foot measures 1.5 [cm] x 1 [cm] and US with slough to wound bed and peri wound intact . New order noted - Cleanse area with wound cleanser, pat dry, apply nickel-thick Santyl, cover with calcium alginate [wound dressing] cut to fit, then border gauze. Change daily and PRN [as needed] if soiled. Order processed. Review of R3's May 2024 and June 2024 Treatment Administration Record (TAR) under the Orders tab of the EMR revealed a physician's order, dated 05/24/24, to Cleanse wound to outer left foot with wound cleanser, pat dry, apply nickel-thick Santyl [ointment used to promote healing] to wound bed, then calcium alginate cut to fit. Cover with border gauze. Change daily et [and] PRN if soiled. The order for the left outer foot wound was documented in the Unscheduled Other Orders section at the top of the page but did not show up in the scheduled orders to be provided. The TARs did not indicate the treatment had been performed for R3's left outer foot wound since it was ordered. Review of R3's Monthly Skin Check, dated 05/28/24 and located in the Assessments tab of the EMR, revealed the skin issue was a skin tear to the top of the left foot measuring 2cm long, 2cm wide, and 0.1cm deep. The assessment did not address the unstageable wound to the left outer foot. Review of R3's EMR revealed no additional documentation of the left outer foot wound, including measurements or assessments. Review of a hospice Progress Note, located in R3's paper hospice binder and dated 06/07/24, revealed, Patient's left foot wound is healed. During an interview on 06/27/24 at 2:02 PM, Licensed Practical Nurse (LPN) 2 stated R3's hospice nurse had notified of a wound to her left outer foot on 05/24/24. He stated the wound was superficial and looked like a blister that popped. LPN2 stated the wound was completely healed and the treatment should have been discontinued. LPN2 stated he did not know if the wound treatment order obtained on 05/24/24 was implemented, as it had been entered wrong into the EMR system and did not populate as a scheduled treatment order. He stated, It must have gotten done though since it's healed. During an observation on 06/27/24 at 2:15 PM in R3's room with the Certified Medical Technician (CMT), R3's left foot was observed with a dry, scabbed, and scarred circular area to the left outer foot below the pinky toe. The area was not open. During an interview on 06/28/24 at 1:30 PM, the Infection Preventionist/Wound Care Nurse (IP-WC) stated typically when a new wound was identified, she would complete a weekly wound assessment to describe the measurements, staging, and characteristics of the wound to monitor for progress. She stated, however, that she did not complete any assessments of R3's outer left foot wound as she messed up. The IP-WC stated she was unsure whether R3's wound care treatment order from 05/24/24 was implemented. During an interview on 06/28/24 at 2:07 PM, the Director of Nursing (DON) stated LPN2 did not enter the 05/24/24 treatment order in the EMR system correctly, so she could not see that the treatment had been done. She stated the LPN should have initiated a schedule to include the treatment order in the active TAR. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R3's June 2024 TAR under the Orders tab revealed a physician's order, dated 09/20/22, for Heel protectors on when in bed as tolerated every day and night shift for Prevention. During an observation on 06/26/24 at 3:20 PM in R3's room, R3 was lying in bed wearing non-slip socks. Her heels were not floated, nor was she wearing heel protectors. R3's heels were in direct contact with the mattress. During an observation on 06/27/24 at 2:12 PM in R3's room, R3 was lying in bed with bare feet, directly in contact with the mattress. Her heels were not floated, nor was she wearing heel protectors. On 06/27/24, Certified Nursing Assistant (CNA) 4 and the CMT entered the room and verified R3 was not wearing heel protectors and her heels were not floated. The CMT stated R3 did not have any heel protectors (boots) and she had never been instructed to float R3's heels. CNA4 confirmed R3 did not have any heel protectors and she had not been instructed to float R3's heels. During an observation on 06/28/24 at 9:59 AM in R3's room, CNA4, CNA6, and the CMT assisted R3 in a transfer from her chair to her bed. The staff did not offer or attempt to apply heel protectors or float her heels. During an interview on 06/28/24 at 10:24 AM, LPN4 stated R3 had an order to use heel protectors as tolerated. LPN4 observed R3 in bed and verified her heels were not floated and she was not wearing heel protectors. He looked in the room and was unable to locate an extra pillow or heel protectors (boots). During an interview on 06/28/24 at 1:30 PM, the IP-WC stated R3 should have had boots (heel protectors) because she was at risk for skin breakdown to her feet. She stated she just did a sweep the other day to ensure all residents who needed them had boots. The IP-WC stated staff should have been applying heel protectors for R3 when in bed and she would have to do more staff education.

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NAME OF PROVIDER OR SUPPLIER Northland Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 NE Parvin Road Kansas City, MO 64117	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review and interview, the facility failed to ensure a resident was free from unnecessary medications when one of five residents (Resident (R) 10) was given two separate doses of psychotropic medications without any documented clinical need for either medication of 25 sample residents. This failure had the potential to affect the safety of all residents who received psychotropic medications. Findings include: Review of R10's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and with diagnoses of depression and anxiety disorder. Review of R10's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 04/11/24, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated R10 had severe cognitive impairment. The resident was coded as being prescribed antipsychotic medication. Review of R10's Care Plan located under the Care Plan tab of the EMR, dated 01/09/24, revealed Administer Antipsychotic medication as ordered. Review of R10 Physician Orders located under the Orders tab in the EMR, dated 06/03/24, revealed start Lorazepam (anti-anxiety medication) one milligram (mg) by mouth every four hours (PO) (orally), PRN (as needed) for restlessness and/or agitation for 14 days and haloperidol 0.5 ml (milliliter) orally every four hours PRN for agitation for 14 days. Review of Treatment Administration Record (TAR) located under the Records tab in the EMR, dated June 2024, revealed on 06/11/24; one dose of Lorazepam one milligram was administered at 4:46 PM and it was effective. However, a dose of Haloperidol 0.5 ml was also administered at 5:45 PM. Further review revealed no behaviors charted for agitation or restlessness on 06/11/24. Review of a "Nurse's Notes" located in the EMR under the "Notes" tab and dated 06/11/24, revealed no documentation about any behaviors or justification for use of PRN Lorazepam or Haloperidol. During an interview on 06/28/24 at 9:18 AM, Registered Nurse (RN) 2 stated staff should have documented in progress notes when a resident was having behaviors that would require a PRN medication and it should also be documented on the TAR under the behavior monitoring. She stated after the initial dose was given staff should have checked in about 45 minutes to an hour to see if it was effective or not and if it was effective, staff would not have needed to administer a second dose of anything. She stated a PRN med should not have been given without justification and it would not have been appropriate to administer a second dose of Haldol if the Lorazepam was documented as effective and that would be unnecessary. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/28/24 at 2:48 PM, the Director of Nursing (DON) stated when administering a PRN medication, staff should have put a note into the progress notes justifying what they were administering the PRN for. The DON stated they should have checked within an hour for effectiveness, and if it was effective, another dose should not have been given. She stated it was not appropriate for either of the PRN medications to have been administered without documentation of justification, or for the second dose to have been administered when the first was effective.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26006 Based on observations, interviews, and facility policy review, the facility failed to store foods in sealed containers in the freezer, ensure the cleanliness of the ice machine, and use adequate hand hygiene during food service in one of one kitchen. These failures had the potential to cause the spread of foodborne illness to all 96 residents. Findings include: Review of the facility's undated policy titled, Kitchen Sanitation provided by the facility, revealed Guideline: To ensure that food prepared in the facility is done so in a safe and sanitary manner. Procedure: The Food Service Manager will monitor food safety and sanitation of the Dietary Department on a daily basis .The Food Service Manager will develop a cleaning schedule for the department and is responsible for its completion .The Food Service Manager will provide written cleaning instructions for each area and piece of equipment in the kitchen. The instructions specify which chemical should be used for each task. During initial observations of the kitchen on 06/25/24 at 9:07 AM, the following were observed: -In the ice machine, a brownish-yellowish-greenish substance was on the inside of the lid. During a concurrent interview, the Dietary Manager (DM) stated the maintenance department was responsible for cleaning the ice machine and had done it recently. -In the stand-alone freezer, there were bags that were open and unsealed containing chicken nuggets, hash brown patties, and hamburger patties. During a concurrent interview with the DM, she stated foods should never be open and unsealed in the freezer. The DM confirmed the chicken nuggets, hash brown patties, and hamburger patties were open and unsealed. She removed the observed items and discarded them. The DM stated she was new to the position and had been focusing on cleaning up the walk-in refrigerator and freezer and had not noticed the open and unsealed items in the stand-alone freezer. During observation of lunch service on 06/27/24 from 11:40 AM to 1:00 PM in the kitchen, the following were observed: -At 11:40 AM, the ice machine was again observed with a yellowish-greenish-brownish substance inside the lid. The plate device was observed with crumbs on the outside. -At 12:03 PM, a breadstick fell from a pan onto the top of the steam table. Dietary cook (DC) 2 put the breadstick back in the pan to be served. -At 12:14 PM, DC2 began to serve meals from the steam table. She donned gloves, then opened the plate warming device and grabbed several plate warmers and plates with her gloved hands. Then, she began plating squares of lasagna using a spatula in one hand, and the other hand in the same glove to slide the lasagna off the spatula. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Throughout lunch service, DC used her gloved hands to open the plate warming device and remove the plate warmers, touched carts holding meal trays, touched oven handles, and donned oven mitts over the gloves, then used the same gloves to pick up breadsticks or pieces of bread for plating. -At 12:32 PM, a meal tray card that had been handled and written on in pen dropped into the pan of breadsticks. DC1 removed the meal tray card using her gloved hands and continued to serve the breadsticks that touched the meal tray card. -At 12:33 PM, DC1 used the same gloved hands to pick up a piece of bread out of the bag for serving. During an interview on 06/28/24 at 2:34 PM, the DM stated she had noticed DC1 and DC2 were using unsanitary gloves to pick up bread and breadsticks during lunch service on 06/27/24. She stated she even tried to correct the staff during service to no avail. The DM stated she expected the cooks to use tongs or utensils to serve all foods and should never touch ready-to-eat foods, even with gloves on, because gloves could become contaminated. The DM also confirmed there was a yellowish-brownish-greenish substance on the inside of the ice machine on the lid. She stated she had not noticed it because she was focused on the ice compartment below. The DM stated the maintenance department had just cleaned the ice machine the week before. During an interview on 06/28/24 at 2:45 PM, the Maintenance Director (MD) stated he cleaned the ice machine monthly and just cleaned it last week. He stated, however, that he did not notice the substance on the inside of the lid, as he was focused more on the ice compartment below. He stated the cleaning involved the entire machine, including removing the ice and changing the filter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, interviews, record review, and facility policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for three of four residents (Resident (R) 247, R14, and R2) reviewed for implementation of EBP with chronic wounds or indwelling devices (intravenous (IV) line, enteral feeding tubes, urinary catheter, or central venous catheter) who were candidates for EBP of 25 sample residents. These failures created the potential to spread multidrug-resistant organisms (MDROs) throughout the facility. Findings include: Review of the facility's undated policy titled, Infection Prevention and Control Manual-Enhanced Barrier Precautions provided by the facility, revealed Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (such as residents that have wounds or indwelling medical devices) .Enhanced Barrier Precautions are recommended for residents with any of the following: 1) Infection or colonization with a MDRO or 2) A wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices include central venous catheters, urinary catheters, feeding tubes, tracheostomies/ventilators. High-contact resident care activities where a gown and gloves should be used include: -Bathing/showering -Transferring residents from one position to another (for example, from bed to wheelchair) -Providing hygiene, -Changing bed linens, -Changing briefs or assisting with toileting, -Caring for or using an indwelling medical device, Performing wound care. 1. Review of R247's Admission Record located in the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses of esophageal obstruction and dysphagia. Since the resident was recently admitted , there was no completed Minimum Data Set (MDS) assessment for review. Review of R247's EMR under the Orders tab, revealed physician's orders, dated 06/13/24, for enteral feeding, enteral tube flushes, and medication administration via enteral feeding tube. Review of R247's Dietician Nutrition Assessment, dated 06/23/24 and located in the Assessment tab of the EMR, revealed She was having difficulty swallowing pta [prior to admission] to hospital and could only tolerate soft foods and liquids. She had a PEG [percutaneous endoscopic gastrostomy] placed and has been on enteral feeding. Review of R247's Care Plan, dated 06/13/24 and located in the Care Plan tab of the EMR, revealed The resident requires tube feeding - Dysphagia, Swallowing problem. During an observation on 06/28/24 at 8:50 AM outside of R247's room, the Hospice Registered Nurse (HRN) entered the room and approached the resident's bedside wearing only a mask. The HRN did not don (put on) a gown and gloves and began to provide care to the resident, including taking vitals and touching the resident's body. The HRN remained in R247's room until approximately 10:00 AM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/28/24 at 10:08 AM, the HRN confirmed R247 used an enteral feeding tube and stated she had been providing hands-on care to R247, including applying topical medications and examining her. The HRN stated she had donned gloves while applying the topical medication but had not worn a gown during her encounter. The HRN stated the facility had not provided information to her regarding EBP, told her R247 should be on EBP, or asked her to wear a gown and gloves while providing high-contact care activities. During an observation of R247 in her room on 06/28/24 at 9:17 AM, Assistant Director of Nursing (ADON) 1 was training Licensed Practical Nurse (LPN) 4 on administering medications and tube feeding via gastrostomy tube (G-tube). LPN4 was assisting ADON1 during resident care. Both staff members performed hand hygiene and donned gloves. Neither staff member wore a gown during resident care. During an interview on 06/28/24 at 10:06 AM, LPN4 stated, Today is my first day here working. The Director of Nursing (DON) gave me verbal training on infection control, and I had to sign off on it this morning . I would have to double check with her if she trained me on EBP. I'm drawing a blank on what that is, but I will ask her and double confirm . I would not need a gown for foley but would do sterile technique. We don't use a gown right now and I'm under the impression that we don't need one for the g-tube . During an interview on 06/28/24 at 10:16 AM, LPN3 stated, I wear full PPE [personal protective equipment] when a resident has COVID, Clostridioides difficile (C-diff), (a bacterium that causes an infection of the colon, the longest part of the large intestine), the flu, or Methicillin-resistant Staphylococcus aureus (MRSA), (difficult-to-treat bacterial infection) in a wound . I wear a gown with g-tube or foley catheter if they are on known quarantine or have other infections going on. I don't wear a gown with normal catheter care or normal g-tube care. During an interview on 06/28/24 at 10:35 AM, LPN4 stated, I asked ADON1 about EBP. She said the protocols are not in place yet. However, they are going to start this week and implement them. During an interview on 06/28/24 at 12:36 PM, ADON1 stated, The protocol to gown up is not in place yet. We are going to start implementing them next week. During an interview on 06/28/24 at 2:19 PM, the Director of Nursing (DON) revealed that she was not aware that CMS [Centers for Medicare and Medicaid Services] had already implemented EBP. The DON stated the facility had purchased EBP signage and put together training materials to begin implementation in the facility next month, July. The DON stated there was currently no policy related to EBP for the facility. 2. Review of R14's Admission Record, located in the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with a diagnosis of neuromuscular dysfunction of the bladder. Review of R14's quarterly MDS located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/13/24, revealed he used an indwelling urinary catheter. Review of R14's EMR under the Orders tab, revealed a physician's order, dated 06/06/24, for use of an indwelling urinary catheter and catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R14's Care Plan, dated 01/24/24 and located in the Care Plan tab of the EMR, revealed, [R14] has a Suprapubic Catheter d/t [due to] Neurogenic Bladder. During an interview on 06/28/24 at 9:50 AM, Certified Nursing Assistant (CNA) 5 described how catheter care was completed. CNA5 stated the staff wore gloves while doing catheter care and then proceeded to list the correct steps in the care process. CNA5 verified the staff always wore gloves during catheter care, but confirmed the staff only put on masks, goggles, or gowns when the staff were aware of something in the resident's urine. During an observation on 06/28/24 at 10:12 AM in R14's room, the Restorative Aide (RA) and CNA4 entered the room to empty R14's catheter bag and provided catheter care. Both the RA and CNA4 donned gloves while providing care; however, neither staff donned a gown. Observation of R14's room entrance revealed no signage or indication that EBP was required, and no PPE supplies were available at the entrance. During an interview on 06/28/24 at 10:21 AM, the RA confirmed neither she nor CNA4 donned a gown while providing catheter care for R14. The RA stated she had been trained in EBP requirements; however, the facility had not yet implemented the use of EBP. During an interview on 06/28/24 at 10:51 AM, the DON stated the facility had not yet implemented EBP and was planning to do so in July. She stated she had already briefly educated the staff, had signs printed, and ordered mounted PPE holders to prepare for implementation of EBP, but staff had not yet implemented the use of EBP. 3. Review of R2's Admission Record located in the EMR under the Profile tab, revealed R2 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder. Review of R2's comprehensive Care Plan located in the EMR under the Care Plan tab, dated 04/05/21, revealed the following focus areas: suprapubic catheter. Interventions in place were to provide catheter care every day shift, change catheter PRN (as needed) for blockage or dislodgement, irrigate catheter as needed, check for kinks during care, monitor and report any pain, discomfort, or any signs of urinary tract infection (UTI). Further review revealed there were no EBP interventions. Review of R2's Physician's Orders, dated 06/05/24 and located in the EMR under the Orders tab, revealed orders as follows: Perform Indwelling Catheter Care (Suprapubic catheter wash catheter site with soap and water daily and flush catheter with 30 ml [milliliter] NS [normal saline] at bedtime. During an observation and interview on 06/25/24 11:31 AM, there was no EBP signage on the resident's door and no cart with PPE near or outside of the resident's room. An interview with R2 at this time revealed staff were not wearing gowns when performing catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/28/24 at 11:37 AM, there was no EBP signage on R2's door and no cart with PPE near or outside of the resident's room. During an interview with the Infection Preventionist/Wound nurse (IP-WC) who was prepped to perform catheter care stated that staff only wore gloves when doing care. She stated that she had heard about EBP but that was not implemented in the facility, and she was aware there was a plan in place. But she was unaware that it became regulatory to have that in place two months ago. She verified there was no signage or PPE placed outside the resident's room. But agreed that any resident who had a chronic wound, indwelling medication device, or central line should have been on EBP. 40902 43353 46592